PREPARATION AND MAILING INSTRUCTIONS
FORM DPA 1443
PROVIDER INVOICE

To facilitate computer processing and to achieve prompt payment of claims, high-speed Optical Character Reading equipment is used to process all billing statements. This equipment is designed to read only typewritten or line- printed characters. If the invoice is handwritten (with the exception of the signature and signature date), the Optical Character Reader cannot be used, and a manual input system is necessary, which is more time-consuming and prone to error. Therefore, it is in the provider's interest to type or line-print all data on the billing statement. The provider should review General Appendix 6 (Technical Guidelines for the Preparation of MMIS Invoice Documents for Optical Scanner Processing) at this point.

Please follow these guidelines in the preparation of invoices for submittal to the Department:

- Use CAPITAL letters only.
- Leave a space between dollars and cents in all amount fields.
- Do not use punctuation or special characters anywhere on the form.
- Do not mark anywhere on the form except in the required information boxes.
- Control Number, if used by billing contractors in the preparation of claims for providers, must be entered in the upper left portion of the invoice in the space immediately below the red elongated arrow and to the right of the "Pica" alignment box. The entry must not extend beyond the center of the page.
- Use a black (preferably mylar) ribbon only.
- To insure that characters are clear and sharp, have your machine serviced and cleaned and the ribbon replaced regularly.
- Strive for accuracy. When correcting errors, use correction fluid.
- Make sure that the form is properly aligned by using the alignment boxes at the top.
- Tabs may be set using the guide dots at the top of the form.
- All dates should be completed in MMDDYY format. This is a six digit entry with no dashes, no slashes or spaces, e.g., January 1, 1998 would be entered as 010198.
- Ensure that both continuous feed and snap-out forms are separated at the perforation lines. Do not cut the forms inside these lines as they are used for correct alignment with the optical character reading equipment.

The left hand column of the instructions identifies mandatory and optional items for form completion. The following categories apply:

Required	Always required.
Optional	Not required. In some cases, failure to enter optional values will result in certain assumptions by the Department. When this is the case, those assumptions are identified in the applicable instruction text.
Conditionally Required	Fields which are required based on an entry in another field. Conditions of the requirement are identified in the instruction text.
Not Required	Fields not applicable to the provision of physician services.

COMPLETION STATUS		**DATA ELEMENT**
		Document Control Number - Leave blank.
Required	1.	**Provider Name** - Enter the provider name exactly as it appears on the Provider Information Sheet (see Appendix A-7).
Required	2.	**Provider Number** - Enter the provider number exactly as it appears on the Provider Information Sheet under "PROVIDER KEY".
Optional	3.	**Payee** - Enter the number of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet. If no number is entered here, payment will be made to the first payee listed on the Provider Information Sheet.
Conditionally Required	4.	**Group** - An entry is required only when a "pay to" address is specified upon enrollment. Enter the appropriate payee number of the group as shown on the Provider Information Sheet.
Not Required	5.	**Role** - Leave blank.
Conditionally Required	6.	**Acc/Inj** - This is a one digit numeric field. When applicable, enter one of the following Accident/Injury Codes to indicate the probable reason the client sought treatment: 1 Employment - The patient's injury is due to work related accident or illness.

COMPLETION STATUS		DATA ELEMENT
		2 Motor Vehicle - The patient's injury was received while operating a motor vehicle or as a passenger in a motor vehicle, or another type of accident involving a motor vehicle.
		3 Athletic - The patient's injury is due to participation in an organized sport or school activity.
		4 Victim - The patient's injury is due to an act of violence (nonaccidental).
		5 Other - The patient's injury is the result of an unspecified accident.
Optional	7.	**Provider Reference** - Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on the Form DPA 194-M-1, Remittance Advice, returned to the provider.
Optional	8.	**Provider Street** - Enter street address of the provider. If the address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If the address is not entered, the Department will not attempt corrections.
Conditionally Required	9.	**Facility & City Where Service Rendered** - Enter the facility name and city where the service was provided. This entry is required when the Place of Service code, in any Service Section, is other than A (provider's office) or K (patient's home).
Not Required	10.	**Prior Approval** - Leave blank.
Optional	11.	**Provider City State Zip** - Enter the city, state and zip code of the provider. See Item 8 above.
Not Required	12.	**Referring Practitioner Name** - Leave blank.
Not Required	13.	**Ref. Prac. No.** - Leave blank.
Required	14.	**Recipient Name** - Enter the patient's name exactly as it appears on the MediPlan Card or a temporary medical card. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.

COMPLETION STATUS	DATA ELEMENT
Required	15. **Recipient No.** - Enter the nine digit number assigned to the individual on the MediPlan Card or temporary medical card. Use no punctuation or spaces. Do not use the Case Identification Number. If the temporary medical card does not contain the recipient number, enter the patient name and birth date on the invoice and attach a copy of the temporary card to the billing form on first submittal. The Department will review the invoice and determine the correct recipient number.
Conditionally Required	16. **Birth date** - Enter the month, day and year of birth of the patient as shown on the MediPlan Card or temporary medical card. Use the MMDDYY format.
Not Required	17. **Healthy Kids** - Leave blank.
Not Required	18. **Fam Plan** - Leave blank.
Not Required	19. **Cr Child** - Leave blank.
Not Required	20. **St/Ab** - Leave blank.
Required	21. **Billing Date** - Enter the date the Provider Invoice was prepared. Use MMDDYY format.
Required	22. **Primary Diagnosis** - Enter the diagnosis which describes the condition primarily responsible for the patient's treatment. (The diagnosis should be provided by the referring specialist or primary physician.)
Conditionally Required	23. **Prefix** - When the diagnosis code has an alphabetic prefix of E or V, enter it here.
Required	24. **Diagnosis Code** - Enter the ICD-9-CM code for the primary diagnosis in Item 22. All characters to the left of the decimal point should be entered to the left of the dividing line. All characters to the right of the decimal point should be entered to the right of the dividing line. Example 388.5 388 | 5
Not Required	25. **Secondary Diagnosis** - Leave blank.
Not Required	26. **Prefix** - Leave blank.

COMPLETION STATUS **DATA ELEMENT**

Not Required 27. **Diag. Code** - Leave blank.

28. **Services Sections** -

Required A. **Procedure Description/Drug Name** - Enter the description of the service provided.

Required B. **Proc. Code/Drug Item No.** - Enter the appropriate procedure code.

Conditionally Required C. **Delete** - When an error has been made that cannot be corrected, enter a capital "X" to delete the entire Service Section. Only a typed "X" is a valid character; all others will be ignored.

Required D. **Date of Service** - Enter the date the service was provided. Use MMDDYY format.

Required E. **Cat. Serv.** - Enter the appropriate two digit code for the category of service provided.

CODE	CATEGORY OF SERVICE
45	Optical Supplies

Required F. **Place of Serv.** - Enter the one letter Place of Service Code from the following list:

CODE	PLACE OF SERVICE
A	Provider's Office
H	Long Term Care Facility
I	Sheltered Care Facility
K	Patient's Home
L	Other Location

Not Required G. **Units/Quantity** - Leave blank.

Not Required H. **Modifying Units** - Leave blank.

COMPLETION STATUS		**DATA ELEMENT**
Conditionally Required	I.	**TPL (Third Party Liability) Code** - As specified in Section I, Chapter 100, Topic 122.2, the provider must determine if the assistance patient has access to a medical resource, other than Public Aid, that is available to meet all or a portion of the claim. The availability and applicability of the resource must be determined by examining the MediPlan Card and by questioning the patient. Physicians providing services to women with a diagnosis of pregnancy or preventive services to children are not required to bill a client's private insurance carrier prior to billing the Department for services provided to clients. In those instances where a resource(s) is identified, a claim is to be filed and adjudicated by the liable third party prior to billing the Department. If the liable third party resource was identified on the patient's MediPlan Card, the TPL Code opposite the patient's name must be entered in the TPL box on the invoice. If the third party resource was not on the patient's MediPlan Card, the appropriate TPL resource code(s) listed in General Appendix 9, must be used. The TPL Code on the MediPlan Card will consist of a three digit numeric code that may be prefixed with an alphabetic coverage code. The three digit resource code identifies a specific health insurance company or other resource. The alpha coverage code defines the extent of services covered by the resource. For example, a client who is insured under a health plan written by the Aetna Life Insurance Company will have 001 printed in the TPL section of the MediPlan Card. Upon definition of the coverage included in the plan, a prefix of alpha "A" code will be added to the TPL resource code (A001) to denote a comprehensive health insurance plan that is underwritten by Aetna. If no TPL is applicable, leave this field blank.

COMPLETION STATUS	DATA ELEMENT

SPENDDOWN - Refer to Chapter 100, Item 105 for a full explanation of Spenddown policy. If the client has a Spenddown obligation, they will either be responsible for the total amount of the charge or will present the provider with a Form DPA 2432 (SPLIT BILLING TRANSMITTAL FOR MANG/AMI, SPENDDOWN PROGRAM). When a Form DPA 2432 is necessary, the Form DPA 1443 should be completed as follows:

1. Enter 906 in the TPL CODE field.
2. Enter an 01 in the TPL STATUS field if there is a client liability or enter an 04 in the TPL STATUS field if there is no client liability.
3. From the Form DPA 2432, enter the amount from the LESS RECIPIENT LIABILITY AMOUNT field in the TPL AMOUNT field on the Form DPA 1443. This amount may be $0.00.
4. From the Form DPA 2432, enter the DATE from the bottom of the form to the TPL DATE field of the Form DPA 1443.
5. The TPL fields will need to be completed in each Service Section that has the same date of service as the Split Bill day. The Spenddown liability will need to be divided and reported in the TPL AMOUNT field of each Service Section. The amount in the TPL AMOUNT field must not exceed the Department's allowable for the particular item.

Be sure to attach a copy of the Form DPA 2432 when submitting the Form DPA 1443.

Conditionally Required

J. **Status** - A two digit code indicating the disposition of the third party billing must be one of the following:

01 - TPL Adjudicated - total payment shown:
TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.

COMPLETION STATUS **DATA ELEMENT**

02 - TPL Adjudicated - patient not covered:
TPL Status Code 02 is to be entered when advised by the third party resource that the patient was not insured at the time goods or services were provided.

03 - TPL Adjudicated - services not covered:
TPL Status Code 03 is to be entered when advised by the third party resource that services provided are not covered.

04 - TPL Adjudicated - Spenddown met:
TPL Status Code 04 is to be entered when the patient's Form DPA 2432, Split Billing Transmittal, shows $0.00 liability.

05 - Patient Not Covered:
TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 - Services Not Covered:
TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending:
TPL Status Code 07 may be entered when an invoice has been submitted to the third party, 30 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

08 - Third Party Estimated Payment:
TPL Status Code 08 is to be entered when contact has been made with the third party and a payment is forthcoming, but has not yet been received. The provider is responsible for initiating an adjustment if the actual amount of TPL monies received differs from the Estimated Amount reported.

10 - Deductible Not Met:
TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the services was because the deductible was not met.

COMPLETION STATUS		DATA ELEMENT
Conditionally Required	K.	**TPL Amount** - Enter the amount of payment received from the third party health resource or the client. A dollar amount entry is required if TPL Status Code 01 or 08 was entered in the "Status" box. If there is no TPL amount, no entry is required.
Conditionally Required	L.	**Adjudication Date** - A TPL date is required when any status code is shown in the Status field. Use the following dates for the specific TPL status codes:

Code	Date
01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from DPA 2432
05	Date of Service
06	Date of Service
07	Date of Submittal to TPL Resource
10	Third Party Adjudication Date

Required	M.	**Provider Charge** - Enter the total charge for the service, not deducting any TPL.
Optional	N.	**Repeat** - In the second through seventh Service Sections, a field titled "Repeat" appears at the beginning of the Service Section. This field may be used, by entry of a typed capital X in the box, to eliminate the need to repeat any data field except the Date of Service and any TPL related fields.
Not Required	29.	**Optical Materials Only** - Leave blank.
	30.	**Charges and Deductions Section** - The information field in the lower right corner of the invoice is to be used: 1) to identify additional third party resources in instances where the patient has access to two or more resources and 2) to calculate total and net charges. If a second third party resource was identified for one or more of the services billed in Service Sections 1 through 7 of the invoice, complete the TPL fields in accordance with the following instructions:
Conditionally Required	A.	**Sect. #** - If more than one third party made a payment for a particular service, enter the Service Section number (1 through 7) in which that service is reported.

COMPLETION STATUS		DATA ELEMENT
		If a third party resource made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in section 30 will be applied to the total of all Service Sections on the invoice.
Conditionally Required	B.	**TPL Code** - Enter the appropriate TPL Resource Code which identifies the source of payment (see General Appendix 9). If the TPL Resource Codes are not appropriate enter 999 and enter the name of the payment source in the Uncoded TPL Name field.
Conditionally Required	C.	**Status** - Enter the appropriate TPL Status Code (see Item J above).
Conditionally Required	D.	**TPL Amount** - Enter the amount of payment received from the third party resource (see Item K above).
Conditionally Required	E.	**Adjudication Date** - See Item L above.
Conditionally Required	F.	**Uncoded TPL Name** - Enter the name of the third party health resource. The name must be entered if TPL code 999 is used.

The billing summary fields must be completed on all invoices. These fields are **TOTAL CHARGE, TOTAL DEDUCTIONS AND NET CHARGE**. These fields are to be completed in accordance with the following instructions:

Required	G.	**Total Charge** - Enter the sum of all charges submitted on the invoice in Service Sections 1 through 7.
Conditionally Required	H.	**Total Deductions** - Enter the sum of all payments received from other sources.
Required	I.	**Net Charge** - Enter the difference between total charges and total deductions.
Required	31.	**# Sects** - Enter the number of Service Sections completed correctly in the top part of the form (from 1 through 7). Do not include deleted Service Sections.

COMPLETION STATUS	DATA ELEMENT
Conditionally Required	32. **Original DCN** - This field must be completed in the following situations. It is not to be completed in any other instances: The Date of Service is prior to 07-01-89 and 1. the Form DPA 1411, Temporary Medical Eligibility Card, was used as proof of eligibility and the service(s) rejected due to a client eligibility error. In this situation, a new invoice is to be prepared and a copy of the Form DPA 1411 attached. (If the Original Document Control Number is not entered, the Form DPA 1411 will be discarded and no attempt will be made to determine eligibility.), or 2. the service was originally submitted during the required 6 month initial submittal period. For Dates of Service 07-01-89 and after, an absolute 12 month limit applies to the processing of both original submittals and resubmittals. It is to the provider's advantage to submit invoices as soon after the Date of Service as practical to avoid exceeding the 12 month limit. In either situation, the exact Document Control Number on the Remittance Advice (Form DPA 194-M-1) which reported the rejected invoice must be entered in the field titled "Original DCN". If more than one invoice has been submitted previously for the service(s), enter the first Document Control Number, no matter how many times resubmittal was made.
Conditionally Required	33. **Original Voucher Number** - Enter the voucher number of the first Remittance Advice, DPA 194-M-1, on which he original rejected invoice was reported. This entry is required when one of the conditions listed in Item 32 exists.
Required	**Provider Certification, Signature and Date** - After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned invoices will not be accepted by the Department and will be returned to the provider, when possible. The date to be entered is the date on which the invoice was signed.

MAILING INSTRUCTIONS

The Provider Invoice is a two-part carbon-interleaf form. Submit the original portion of the form to the Department as indicated below. The tear strip should be detached from continuous feed forms. The carbon copy of the claim is to be retained by the provider.

Mail routine invoices to the Department in pre-addressed mailing envelopes, Form DPA 1444, Provider Invoice Envelope, which is supplied by the Department.

Mail non-routine provider invoices to the Department in pre-addressed envelopes, Form DPA 1414, Special Approval Envelope, which are supplied by the Department for this purpose.

Non-routine invoices are invoices which require an attachment. DO NOT STAPLE ATTACHMENTS. Use paper clips only. An invoice to which a temporary medical card is attached is considered non-routine.